IM-64 INSTRUCTIONS

REQUEST FOR PARTICIPANT MO HEALTHNET REIMBURSEMENT

PURPOSE: To provide a method of notifying the MO HealthNet Division (MHD) that a participant is requesting reimbursement for incorrectly denied paid medical expenses.

NUMBER OF COPIES AND DISPOSITION: Send original to the MHD and retain a copy in the case file.

INSTRUCTIONS FOR COMPLETION: This form may be typed or handwritten.

FSD Office – Enter the local office name.

Eligibility Specialist – Enter the name of the eligibility specialist (ES).

Telephone number – Enter the FSD office telephone number.

Claimant– Enter the full name of the claimant.

DCN – Enter the claimant's DCN.

Claimant's Spouse – Enter the full name of the claimant's spouse, if included on the case.

DCN – Enter the claimant's spouse's DCN.

Section A - Complete the identifying information at the top of the form and Section A during the interview with the claimant.

In the first date field, enter the date the rejection or closing action which denied MO HealthNet benefits. In the second date field enter the date of the hearing decision, or the date the ES and supervisor agree and notify the claimant that an incorrect decision was made to deny benefits.

Have you made payment for any medical services which you or a member of your assistance group received from:

If the claimant has not paid for medical services received between the two dates discussed above, check the "NO" response. The claimant and ES should sign and date the form. Send the original to the MHD and retain a copy in the file.

OR

If the claimant has paid for medical services received between the two dates discussed above, check the “YES” response. The claimant and ES should sign and date the form. Proceed to Section B.

Section B: If the claimant responded “YES” in Section A, determine eligibility and complete Section B.

If the claimant is determined ineligible, check “NO” and send the form to the MHD.

OR

If the clamant is determined eligible, check “YES” and proceed to Section C.

Section C:

What were the circumstances which prompted the agency action to reverse the original denial of eligibility?

ES should answer the question.

Is spend down involved?

If the claimant is not on spend down, check the “NO” response. If “NO” response is checked, the form is complete.

OR

If the claimant is on spend down, check the “YES” response. Fill in the spend down eligibility dates during the time period specified on the form, which may include one or more months.

If more than 12 months are involved, please specify: If claimant was incorrectly denied more than 12 months and have expenses for those months, list additional months here.

Other members of the assistance group eligible during the above period – Enter the name and DCN of others in the assistance group for multiple person cases. List ONLY those members who were eligible for MO HealthNet coverage.

Send the completed form to the MHD.